

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

16712

1. PLACE OF DEATH

County.....
Township.....
City St. Louis Mo.

Registration District No. 791
1003
Primary Registration District No. MO. Baptist Hospital

File No. 4820
Registered No.
St. Ward)

2. FULL NAME Lola Robinson

(a) Residence. No. St. 12 Ward. Richland Mo.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. I da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Joe W. Robinson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 8/ 1902

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>27</u>	<u>5</u>	<u>19</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) Young County
(STATE OR COUNTRY) Texas

10. NAME OF FATHER J. H. Mattishard

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY) Miss.

12. MAIDEN NAME OF MOTHER Callie Falley

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY) Tenn.

14. INFORMANT Joe W. Robinson
(Address) Richland Mo.

15. Filed..... 19 27 1929
May C. Harlow REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 27 1929

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., and that I last saw h..... alive on..... 19....., and that death occurred on the date stated above, at..... I: 10 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Shock & Burns
1st & 2nd Degree
Due to clothing becoming
ignited while attempting to
pour kerosene out of
fire (Burning Building)

18. WHERE WAS DISEASE CONTRACTED Accident
IF NOT AT PLACE OF DEATH.....
DISEASE OPERATED BEFORE DEATH..... DATE OF.....

19. (AS THERE AN AUTOPSY?)
WHAT TEST CONFIRMED DIAGNOSIS.....
(Signed) J. W. Kerner, M.D.
4/27/29 (Address) Dep. Coron

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Richland Mo. DATE OF BURIAL 4/30 1929

20. UNDERTAKER Temple Und. ADDRESS Richland Mo.

N. H. ... should be carefully supplied. AGE should be stated EXACTLY. OCCUPATION should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis (No. 200125121) St. 1 (Ward)

File No.
 Registered No. 4829

2. FULL NAME

(a) Residence. No. 200125121 St., Ward.
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1901 08-19-02

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
27 3 19

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work
- (b) General nature of industry, business, or establishment in which employed (or employer)
- (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED 1111 - 8 1929 May C. Starker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 27 1929

17. I HEREBY CERTIFY That I attended deceased from 19..... to 19..... that I last saw him alive on 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

Goble & Co. Rolland Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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